Advance Care Planning – A Framework for the Central Region 2014
The Health of Older People Network would like to acknowledge the contribution of the working group members in the development of the Advanced Care Plan Framework for the Central Region:

**Kirsten Holst**, Physician and Geriatrician (MidCentral DHB), **Liz Elliott**, Nurse Co-ordinator (MidCentral DHB), **Trevor Daniell**, Consumer Representative (Capital & Coast Region), **Vicky Noble**, Primary Health Care & Integrated Care (SIDU, Capital & Coast DHB), **Zainab Contractor**, Senior Medical Officer – Geriatrics and Rehabilitation Medicine (Hutt Valley DHB), **Jennie Fowler**, Strategic Advisor for Health of Older People (Whanganui DHB), **Lucy Fergus**, Geriatrician (Hawke’s Bay DHB), **Leigh White**, Clinical Nurse Specialist (Hawke’s Bay DHB).
## Contents Page

FOREWORD - Why would we even want to think about dying? ................................................................. 6

Executive Summary .......................................................................................................................................... 8

SECTION 1: Social Model for Change ........................................................................................................... 10
  Why the framework was developed ........................................................................................................... 10
  Relevant Reading ........................................................................................................................................ 13

SECTION 2: Desirability ............................................................................................................................... 14
  What is an Advance Care Plan? .................................................................................................................. 15
  ACP in New Zealand: Cultural Heritage and Values .................................................................................. 18
  Relevant Reading ........................................................................................................................................ 18

SECTION 3: Enabling Context ..................................................................................................................... 20
  Governance .................................................................................................................................................. 21
  Health Workforce New Zealand ACP Funding ............................................................................................ 23
  ACP Documentation .................................................................................................................................... 24
    Relevant References ................................................................................................................................... 25

SECTION 4: ‘Can Do’ ..................................................................................................................................... 26
  Level 1 ACP Training Programme ............................................................................................................. 27
  Level 2 Training Programme ....................................................................................................................... 29
  Level 3 ACP Training Programme ............................................................................................................. 32
  Projected Costs of ACP Training ................................................................................................................. 33
    Relevant Reading ....................................................................................................................................... 34

SECTION 5: Creating the Buzz ....................................................................................................................... 35
  Raising Awareness with the General Public ............................................................................................... 36
  Raising Awareness within the Health Sector ............................................................................................... 37
  Relevant Reading ........................................................................................................................................ 37
SECTION 6: Invitation

The ethical challenges of ACP conversations

Consumer Resources

Relevant Reading

SECTION 7: Sustained Adoption

Health Sector Adoption of ACP

Community Adoption of ACP

Relevant Reading

Glossary

Appendix 1: Central Region ACP Contacts

Appendix 2: Stocktake of ACP Implementation Across the Central Region

Appendix 3: Survey of ACP Trained Staff in the Central Region

Appendix 4: Regional View of ACP Training

Appendix 5: Workforce Analysis Methodology

Figures

Figure 1: Based on the 5 Doors of Change

Figure 2: National ACP Cooperative Advance Care Plan Model

Figure 3: Scope of an Advanced Directive, and ACP and an ACP Conversation

Figure 4: Governance relationships for ACP

Figure 5: ACP Competency and Training Model – adapted from the Co-operative

Figure 6: New Zealand Triple Aim

Tables

Table 1: Recommendations for ACP implementation

Table 2: Projected Level 1 training numbers in primary care and community settings
Why would we even want to think about dying?

"I imagine it would be true to say that for most of our day, we do not spend our time thinking about dying. We usually have far far better things to do, like the ironing, wondering what we’ll wear next (or wondering why someone would really care about that), or ensuring that a really good coffee is never more than five minutes away. We see death on the news, watch it at the cinema, read about it in books, but it is almost always something that happens to someone else - never me.

In health care, many of us are exposed to dying on a frequent basis, and it can often be quite confronting and distressing. And sometimes it does make us think ‘what would I want if I were in this patient’s shoes?’ And then we may move on, and the warm comforting thoughts of immortality quickly return, eclipsing any uneasy thoughts about ‘our end’.

The thing is, when people are asked if they would like to be able to have a say about what would be important to them if they were dying, the vast majority of people say ‘yes’. They often want an opportunity to talk about the ‘what ifs’ and the end of life, especially as they get sicker. The chance to let our doctors and people looking after us know what really matters to us, and to be able to influence our care at the end of life, resonate deeply in a culture that strongly values autonomy, inclusion in decision making, and choice.

Our values with respect to life and death can be imagined as a spectrum, with living as long as possible, no matter what, at one end; with living as well as possible, with length as secondary, on the other. Some of us strongly identify with the poles, whilst the majority are somewhere in between.

And we also change our perspective on life and dying as we age, and as we deal with increasing illness and life events. My response as a twenty year old, newly in love and spreading my independent wings to how I would want to be treated if severely brain injured in an accident, is quite different than if asked today, some thirty years later (and still in love), and may be different again in another thirty years (and hopefully still in love).

From a health carer’s perspective, it is extraordinarily helpful to know how the people we care for are thinking about their illness and the situations they find themselves facing: especially their hopes, goals, fears, wishes and preferences for future care. As they get sicker, the more we know about their perspectives about death and dying, the more we are able to best help them. Unfortunately, we are not that good at predicting what goals a person might make unless we ask them. We are just as likely to predict someone may want a life saving intervention and get it wrong, as we are get it right. This is counter to what most of us would assume: we like to think that we know how our patients think and make decisions. The evidence is often to the contrary!

Advance care planning (ACP) is a way of thinking about someone’s future care that has developed over the last twenty years as a response to society’s increasing push for individual rights, choice, and care that is meaningful to a person. It has also been driven by clinicians worried that as the boundaries of medicine continuously expand and become ever more complex, that there is a need to ensure that we don’t simply do what we ‘can do’, but rather do what we ‘should do’ in response.
ACP is at its most basic an information gathering exercise, a listening and sharing of views, and a development of a set of future care principles: it informs medical professionals and helps us make sure we are making medical decisions that are in somebody’s best interests as they get sicker and approach death. Done well, they help clarify goals of care, delineate limits of interventions, and support meaningful care targeted specifically to an individual at life’s end.

There are clearly many reasons to support a development that aims to improve end-of-life decision making and enhance care. However, as with any idea vested with worthy intentions, it would be wrong to accept without acknowledging any potential problems. Whilst our common law legal system and the Health and Disability Commissioner support advance care planning leading to advance directives, there are several legal areas of grey which need clarification at high level so as to avoid ambiguity and uncertainty. Our information systems need to develop to support any care plans being available immediately wherever the person may be.

Also, whilst there is an increasing evidence base showing benefits, this needs to be expanded and confirmed with even more good quality research. And the public and professional understanding of what this is, and is not, needs to be clarified. For instance, ACP is not a right for a patient to demand clinically inappropriate therapies (including resuscitation), nor is it ‘euthanasia by the back door’. Finally, there is a need to discuss how this planning can be better incorporated into our every day working practice. Having conversations takes time; we may feel we don’t have the particular skills to have these delicate conversations; or we may feel that it is somebody else’s business.

It seems to me that there are many similarities between someone starting to create an advance care plan, and our current clinical, organisational and professional approach to supporting their implementation. Both are ongoing discussions and work, both have areas of grey and uncertainty that need time, wisdom and further development to make them as useful and applicable as possible, and both have the ultimate goal of improving decisions and care at the end of life.

So thinking about dying might well have its benefits after all! And if you want to think about it more, check out the National ACP Cooperative’s website — whether from your own personal or professional perspective: http://www.advancecareplanning.org.nz

Dr Jonathan Adler
Palliative Medicine Physician
Clinical Leader Wellington Regional Hospital Palliative Care Service
Capital & Coast DHB

1 http://ccdhbcheckinwelcome.blogspot.co.nz/
Executive Summary

Advance Care Planning (ACP) assists in the provision of quality health care and is becoming increasingly important, due to the growing range of health treatment options available and the enhanced recognition of shared decision-making. The value of ACP is that it gives the person the opportunity to develop and express their preferences for end-of-life care based on their personal views and values, a better understanding of their current and likely future health, and treatment and care options available to them.

Organisations and health care professionals need to be prepared to talk about ACP. They need to be capable of asking about and understanding what matters most to the person, and respecting their end-of-life wishes.

The National ACP Co-operative is a national collective of people driving a collaborative approach to the design and implementation of ACP in New Zealand. ACP training is an important component of the Co-operative’s strategy and is supported by Health Workforce New Zealand (HWNZ). There are two levels of training designed to build a health care professional’s understanding of ACP. Level 1 is module based E-learning which is available free from the National ACP Co-operative website. It is designed for health care workers interacting with people and their families who need to improve their understanding of ACP. Level 2 is practitioner level and is aimed at health care professionals who want to improve their communication skills and ACP documentation.

For sustained adoption of ACP, social change needs to occur across the community and in the health sector. Social change needs to occur across a diverse audience where the central message is the same, but which requires different approaches.

It is important that the Central Region District Health Boards (DHBs) align with the national direction and develop a regional response to ACP to ensure an integrated and seamless approach for its population.

There is growing knowledge and understanding of ACP within the Central Region. However it is anticipated that building workforce capacity will take several years. DHBs need to take a long term view as ACP training requires a significant investment of time and financial resource.

Critical to the implementation of the recommendations outlined in table 1 is the support from DHB leadership teams.

<table>
<thead>
<tr>
<th>Section of Report</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling Context</td>
<td>1. Collaborate with the National ACP Co-operative and the National ACP Round Table to ensure consistency of approach and implementation of ACP in the Central Region.</td>
</tr>
<tr>
<td></td>
<td>2. ACP leads are identified and supported locally or sub-regionally to implement an ACP framework and assist in driving the changes required.</td>
</tr>
</tbody>
</table>
Section of Report | Recommendations
--- | ---
3. | ACP governance groups are established at a local or sub-regional level that include stakeholders from across the health and community sector, to progress the implementation of ACP.
4. | Organisations develop guidelines or policies consistent with the Central Region ACP framework to support implementation at a local level.
5. | The Central Region Training Hub provides the governance function for ACP training regionally.
6. | That a request be made to the Central Region Health Informatics Strategic Advisory Group (CRHISAG) to give urgent consideration to determining, as a regional priority, the need for electronic management of ACP documentation.

Can Do | 7. DHBs and PHOs collaborate to develop a 3-5 year workforce plan that reflects medical, nursing and allied health requirements.
8. | Level 1 ACP training is prioritised as it builds capacity and capability to engage in ACP conversations.
9. | Level 2 training is targeted to specific health care professionals.

Creating the Buzz | 10. The Central Region builds on national and local resources ensuring consistency of communication and messaging such as developing regional presentation packages for raising awareness.
11. | Local or sub-regional clinical champions and community champions are identified to raise the awareness of ACP.
12. | ACP is integrated into clinical pathways, such as dementia pathways, so when a person expresses advance care preferences, health care professionals are able to provide support.

Invitation | 13. Good quality ACP resources are branded with the six DHB logos cementing the community message that this has regional endorsement and currency with all health care professionals across the region.

Sustained Adoption | 14. At a minimum the Central Region collects and reports on the same outcome measures used by the Northern Regional Alliance.
15. | DHBs collaborate locally and regionally to develop agreed primary care, aged residential care and DHB measures.
16. | The regional ACP project team (2013/2014) phase into a regional group which supports ACP implementation and escalates local innovations and regional collaboration for 2014/2015.

Table 1: Recommendations for ACP implementation

It is anticipated that implementation of these recommendations will be initiated in 2014/2015 with governance from the Health of Older People Network.
SECTION 1: Social Model for Change

Why the framework was developed

The Central Region population is approximately 879,000 people. For the District Health Boards delivering services to their population there are several challenges driving how care needs to be delivered now and into the future.

- ‘Demographic changes: Our population is ageing. Between 2014 and 2024, there is a projected 33.1% growth in the population aged 65 to 84 years, and 29.2% growth in the 85+ years.
- Epidemiology: More people are living longer with one or more long term conditions. In New Zealand, cancer and cardiovascular disease are the leading causes of early death and disability. Mental health disorders are the third-highest cause of health loss and affects younger people.
- Consumer and public expectation: Public expectations of health services are changing rapidly. People, consumers, family/whānau expect to receive more personalised care, are focused more on quality of care and are often much better informed about their treatment options."

The Regional Service Plan (RSP) 2013/2014 identifies that a health system that functions well for the health of older people is one that

- provides choice,
- involves older people and, where appropriate, the older people’s families/networks/key support persons in making decisions about their care,
- provides clear information,
- protects vulnerable older people and
- is integrated around the older person (not just what fits the system) to improve their overall quality of life.

To support that vision a common priority for the Central Region DHBs was to develop a regional framework for advance care planning.

What is the purpose of the ACP Framework for the Central Region?

The Central Region DHBs acknowledge the expertise and commitment of the National ACP Co-operative in deploying ACP within New Zealand. However the National ACP Co-operative cannot drive ACP implementation at a local or regional level.

The purpose of this framework is to provide the Central Region with a shared understanding of advance care planning, consistent language to support ACP implementation locally and a resource to support a well-informed implementation process. It promotes alignment with the national direction, but is flexible enough to support regional and local priorities and innovations.

---

2 Central Region DHBs Regional Service Plan 2014/2015
Such regional priorities for 2014/2015 are the development of Dementia Pathways and a Palliative Care Strategy.

A regional approach should result in better support for health care professionals across the region, with greater peer support and the provision of peer review and training opportunities.

To support regional collaboration and networking, Appendix 1 identifies key contacts within the Central Region for ACP.

**Les Robinson’s Social Model for Change**

For sustained adoption of ACP, social change needs to occur across the health sector and from the wider community. Les Robinson describes a generic model for social change which can be easily applied to ACP. As outlined in figure 1, the 5 Doors model

‘works as a checklist of factors to keep in mind when designing a programme. The model consists of five factors. The theory is not about changing knowledge, beliefs or attitudes. It’s very much about enabling relationships between people and modifying technological and social contexts. The principle for sustained adoption of a behaviour is that all five of the conditions need to be present. Sustained behaviour change means people must believe they are getting an outcome that matters in their work or their lives.’

![Figure 1: Based on the 5 Doors of Change](image)

---


The model suggests that social change is linear or stepwise, which it is not. However it does frame the critical components that need consideration for successful adoption of ACP.

National ACP Co-operative’s Advance Care Planning Deployment Model

The National ACP Co-operative has adapted the Canadian Model for ACP deployment. As identified in figure 2 the building blocks are interlinked and it is encouraged that these are developed concurrently. People and their family/whānau are at the centre of the model.

Critical factors for success were identified from the Canadian experience. Several of these are:

- **Secure support from organisational leaders.**
- **Bear in mind that ACP calls for a culture change and is not simply a process that includes systems and policies.**

---

National Advance Care Planning Level 2 teaching resource Day 1, Slide 10.
• Be flexible in your implementation process: pay close attention to cues from the public and health care providers and respond appropriately.

• Begin with a small group of health care professionals who are well informed and thus able to move the initiative forward, and who are committed to making the required changes in practice and in organizational structures.

• Engage a passionate champion for the initiative—someone who can inspire passion for advance care planning in others.

• Engage all disciplines in implementing formal education strategies for health care providers and in sharing the initiation of ACP conversations with individuals.

• Engage the community throughout your process.⁶

These critical success factors are reflected within the ACP framework for the Central Region.

Relevant Reading


SECTION 2: Desirability

‘ACP is a concept that was introduced internationally in the late 1980s but has only gained momentum in New Zealand in recent years. ACP assists in the provision of quality health care and is becoming increasingly important, due to the growing range of medical treatment options and the enhanced recognition of shared decision-making’.  

The National ACP Co-operative is a collective formed in 2010 by health care professionals tasked with driving a collaborative approach to the design and implementation of ACP services in New Zealand. Key priorities for the National ACP Co-operative are:

- ‘Consistent language and documentation in regard to ACP.
- Public engagement and education with ACP.
- Staff training in ACP and communication.
- Cultural appropriateness.’

It is important that the Central Region DHBs align with the national direction and develop a regional response to ACP to ensure an integrated and seamless approach for its population. Drivers in the Central Region for progressing ACP are similar to those experienced elsewhere.

- There is an increased expectation of receiving and delivering person-centred care.
- Our population is ageing and people are living longer.
- The number of people living with one or more complex diseases, disabilities or conditions is increasing.
- The person’s journey through health services is often fragmented, episodic in nature and across DHB boundaries.
- It aligns with other health priorities such as dementia pathways.

‘Advance care planning will not resolve all difficulties related to care decisions for an incapable patient. It may not be possible to fulfil all of an individual’s care wishes. For example, a person may express a wish to die at home, but the material and emotional resources of the family and the resources of the health care system may not be able to sustain care at home until the end-of-life.’

---


29.4% increase in people aged over 85 years since 2006 representing 73,000 people nationally.

32% increase in those aged 65-69 years of age nationally since the 2006 Census.

29.8% increase in those aged 60-64 years of age nationally since the 2006 Census.

14.6% of the NZ population identify themselves as Māori.

11.8% of the NZ population identify themselves as Asian.

7.4% of the NZ population identify themselves as Pacific peoples.
What is an Advance Care Plan?

ACP is a process of discussions and shared planning for future health care. It is a voluntary process which involves the person, their family/whānau and health care professionals and is a process that is revisited throughout their journey. ACP gives people the opportunity to develop and express their preferences for end-of-life care based on

- their personal views and values, and where acceptable to the person their views of family/whānau,
- a better understanding of their current and likely future health, and
- the treatment and care options available.

An ACP conversation may be documented either on a specific form or within a location that is accessible to others, now and in the future. The ACP process should

- empower the person to make informed decisions about their future care,
- guide decision-making when a person loses capacity to make their own decisions,
- allow the person to share with family/whānau or with an enduring power of attorney holder and care provider their values and beliefs around future care options,
- be consistent with and considered alongside other advance directives that exist and
- be regularly reviewed and updated as and when situations change.

Well implemented, an ACP will ensure that the future treatment and care of each person is aligned with their preferences, values and beliefs and that it is available to others.

What issues are discussed in an Advance Care Plan?

ACP discussions may cover:

- ‘A person’s understanding of their illness and prognosis.
- The types of care and/or treatments that may be beneficial in the future and their potential availability.
- Preferences for future care and/or treatments.
- Concerns, fears, wishes, goals, values and beliefs.
- Preferred place of care (and how this may affect the treatment options available).
- Who in their family/whānau or others that they would like to be involved in decisions out their care.
- Views and understanding about interventions that may be considered or undertaken in an emergency (such as cardiopulmonary resuscitation).

• Needs for religious, spiritual or other personal support.^{11}

**The value of an Advance Care Plan**

“The introduction of ACP as a key component of health care is integral to achieving high-quality care and should be regarded as part of the role of all health care practitioners and services. There is a growing public expectation that an individual’s wishes for medical treatment, including end-of-life care, will be respected, even if a progressive disease has affected their decision-making capacity.

In essence, effective ACP has the following outcomes:

- It encourages conversations about what is important for a person, providing them with the opportunity to discuss their hopes and expectations, as well as their fears and anxieties about their future health and about death and dying. ACP allows a person with a life-limiting condition to plan in advance for appropriate care at end-of-life (Hudson and O’Connor 2007).

- It helps a person achieve a sense of control as their illness progresses and death approaches. It reassures the individual that others are aware of their values, goals, priorities and expectations for the final phase of their life. Central to ACP is the opportunity, knowledge, appropriate advice and support for the person to plan their future medical care, including end-of-life experience and treatment (Lyon 2007).

- It engages others, including, where invited, family/whanau and caregivers, in the ACP process to help them understand the person’s wishes and to support them through the process. A greater engagement of others places those others in a better position to actively participate in decision-making when the person can no longer make decisions themselves.

- It reassures the person that discussions and plans can change over time and in particular if circumstances change. ACP is an on-going process that allows plans and documents to be reviewed regularly and as necessary.”^{12}


**Advance Directives and Advance Care Plans**

“Advance care planning is not limited to the preparation of a legal advance directive, although it may include this. Some individuals may feel satisfied after they have engaged in a process of communication and reflection and have shared their care wishes with those close to them and/or with their healthcare providers. Others may wish to prepare a legal advance directive naming a proxy (someone who decides for them, if he/she has been deemed to be no longer capable of giving informed consent to treatment)\(^{13}\)”

An Advance Directive is often confused with an ACP.

- **Advance Directives (AD)** are statements about medical care in the future should a person cease to be competent to make decisions. It usually sets out circumstances where someone would wish certain care to be withheld and is binding on doctors if those circumstances arise. An AD may be a separate document or part of an ACP.

- **Advance Care Plans** are the desired outcomes of the ACP process and conversation. Ideally, it is documented on a form designed for that purpose, though it can be in any format.

- **Advance Care Conversations** are conversations between a health care professional and a person and/or their family/whānau about future health care. It is a conversation that gives a person the opportunity to develop and express their preferences for end-of-life care.

This scope and breadth of an AD in relation to advance care plans and advance care conversations are demonstrated in figure 3.

---

**Figure 3: Scope of an Advanced Directive, and ACP and an ACP Conversation\(^{14}\)**


\(^{14}\) Diagram used with permission of the National ACP Cooperative
ACP in New Zealand: Cultural Heritage and Values

‘New Zealand is a multicultural society, and ACP, like all areas of health care, needs to be sufficiently flexible to be culturally appropriate for all individuals in our society. There are differing cultural practices around dying and death that also need to be acknowledged and respected in ACP practices. Health care professionals must be sensitive to different cultural perspectives on how decisions are made and by whom, because there are differing views of autonomy, beliefs and values and how these elements are respected.

Fundamental to all health approaches in New Zealand is the firm commitment to the cultural considerations of our heritage and to honouring Te Tiriti o Waitangi. The concept and practice of ACP, in its purpose and intent of empowering an individual and their family/whānau to participate in their own health care, are closely aligned within Te Whare Tapa Whā and the Whānau Ora strategy to promote a model of care that builds upon Māori values, aspirations and intent.

Additionally, the concept of ACP aligns with the Pacific health model of care that supports Pacific peoples who are receiving care in the community and ‘by Pacific for Pacific’. Further resources need to be developed with health service providers with the aim of aligning ACP principles and practices within specific cultural frameworks and models for health care15.

‘Advance care planning provides a process that supports diversity and enquires about values and goals of individuals from all cultural backgrounds. Experience shows that advance care planning models can be successfully adapted by and for diverse cultural communities16.

The National ACP Co-operative is leading development of multicultural resources. However a local DHB response will be required to support communities as well as the local workforce.

Relevant Reading


Desirability for Social Change – The Application to ACP

- ‘The process of ACP is a reflection of society’s desire to respect personal autonomy while also holding to the traditional medical values of beneficence (the moral obligation to act for the benefit of others) and non-maleficence (the obligation not to inflict harm on others).’

- In NZ desirability is assumed as ACP training and raising awareness initiatives are driven nationally and training is funded by Health Workforce NZ.

SECTION 3: Enabling Context

The National ACP Co-operative is a national collective of people driving a collaborative approach to the design and implementation of ACP in New Zealand. The National ACP Co-operative will work together to develop a common understanding, framework and direction for ACP in all areas of health for our communities. The Central Region health sector and community contribute to this national collective through a variety of roles.

The National ACP Co-operative alongside the Central Region governance structures provides an enabling context for the social change required for ACP implementation. Participation in ACP training and participation in local or sub-regional governance groups will build self-efficacy in the workforce.

Principles

- Collaboration with the National ACP Co-operative and the National ACP Round Table to ensure consistency of approach and implementation of ACP.
- Commitment to working alongside HWNZ in developing ACP with health care professionals.
- ACP governance groups within the Central Region utilise a collaborative and continuous quality improvement approach to support the acceleration of change/improvement required.
- ACP needs to be championed by Executive Leadership Teams and included in Annual Plans for DHBs and PHOs, Alliance contracting and the like.
- Collaborative ACP leads are identified and supported locally or sub-regionally to implement the ACP framework across the community, primary and secondary services.
- Organisations develop local guidance or policies consistent with the Central Region ACP framework.
- ACP conversations and processes are integrated within local frameworks and pathways.
- Conversations are captured and documented on an ACP form which is available to all health care professionals at all points of care.
- Local personnel are identified to provide support to the National ACP Co-operative to facilitate the delivery of local Level 2 ACP courses.

---

18 Our voice: tō tātou reo. Advance Care Planning website: www.advancecareplanning.org.nz/aboutACP/
Governance

Local/Sub-regional Governance

All DHBs within the Central Region have special interest groups or ACP project-related ACP groups. In lieu of developing additional ACP groups, it is recommended that these existing interest groups phase in governance activities. Figure 4 provides a guide to the relationships that these governance groups may have.

Figure 4: Governance relationships for ACP

Local/sub-regional ACP governance groups should be broadly representative of all ACP stakeholders in the local population. Suggested stakeholders are:

- One or more clinical and community champions for ACP.
- Hospital services such as cardiac, renal, respiratory, other complex long term conditions, health of older people and palliative care services.
- General practice teams which could include general practitioners, nurses, allied health or hospice/palliative care specialist.
- Community representatives such as consumer, residential care provider, disability support provider, home and community support, lawyer or paramedic.
- Non-government Organisations such as IHC New Zealand, Age Concern or Alzheimer’s Society.
- Management representative such as Medical Head of Department, Primary Care/PHO Manager/Aged and residential Care Provider or Health of Older People Portfolio Manager.
- Wider cultural and ethnic representation.
- Representatives of levels 2 and 3 ACP-trained individuals.

Locally or sub-regionally there should be a governance group tasked with the following:

- Developing local strategy for implementation of the ACP framework, recognising the need for a phased approach.
- Working in partnership with community services, primary and secondary care.
- Implementing local policies and guidelines.
- Being the source of engagement with the Regional Director of Training.
- Supporting the regional training hub network to deliver local ACP courses.
- Annually reviewing the ACP training framework with the Regional Director of Training, define any variability, define any issues and recommend improvements.
- Endorse local applicants for ACP training.
- Providing peer support to locally-trained ACP workforce.
- Commitment to sharing locally developed resources with other Central Region ACP governance groups to reduce duplication of effort and share innovations.
- Setting, monitoring and reviewing goals for ACP implementation at a local level.
- Annual feedback of ACP implementation to Executive teams and to the Regional Training Hub.

To be effective governance groups will require a range of organisational support which may include administration support and communication resource.

**Regional Training Governance**

The Central Region Training Hub and Training Network provide an important governance function for regional ACP training. The role of the Regional Training Hub is to

- be the central point for engagement with HWNZ and with the Co-operative for any regional training initiatives,
- manage the database of Level 1, Level 2 and Level 3 ACP-trained staff in the Central Region and map against the ACP training framework,
- assist local governance groups to develop an appropriate and equitable spread of ACP-trained health care professionals across the region,
- liaise with local ACP governance groups to ensure training courses are filled,
- co-ordinate and support the delivery of ACP courses through the Training Hub Network.
• liaise with Level 3 trained staff at least annually to understand any regional training implications such as the need for new Level 3 ACP trainers
• annually reviewing the ACP training framework with ACP governance groups, define any variability, define any issues and recommend improvements and
• make available to health care professionals who enquire from within the Central Region the names of Level 2 and Level 3 ACP-trained staff in a DHB region19.

Health Workforce New Zealand ACP Funding

In August 2012 Health Workforce New Zealand (HWNZ) allocated $62,900 to each region to support the implementation of ACP and signalled on-going support during subsequent years. However in October 2012 HWNZ recouped the funding as it was identified it was too early to have this process managed regionally. It remains unclear at this stage if there will be funding from HWNZ on an annual basis and how this will be disseminated going forward.

HWNZ via the Northern Regional Alliance (NRA) has been subsidising Level 2 training. The subsidised cost is $900 per person (excluding travel and accommodation). The Central Region has spent approximately $100,00020 on ACP training in the last two years.

Training has been designed nationally and rolled out from the National ACP Cooperative. The Central Region stocktake undertaken in April 2013 identified that decisions around training were often rushed and there was little opportunity for DHBs to be thoughtful in their selection of people to be trained (refer Appendix 2). The National ACP Co-operative has responded to feedback and training dates are now being scheduled 6-12 months in advance. However recruitment barriers related to cost of training remain.

If HWNZ allocate and devolve funding in 2014/2015, the Regional Training Hub should administer this funding on behalf of Central Region to ensure those trained align with the training strategy nationally and regionally.

ACP Leads

ACP leads co-ordinate the local governance groups and assist in championing ACP at a local level. The approach to these leads will be different for each DHB (tertiary versus smaller rural DHB) and there is no expectation that new positions are created to fulfil these roles21.

ACP requires a level of change across all parts of the health sector, therefore it is desirable that leads are identified for primary and secondary care and that these leads collaborate to ensure an integrated approach across their region.

19 The Cooperative is reviewing the consent statements on their registration form to enable this information to be shared, where the DHB or a health agency has funded training.
20 Estimate based on numbers trained multiplied by the training cost
21 Some Central Region DHBs and PHOs already have identified leads or champions.
ACP Documentation

Each person is the owner of their ACP. Where a treating health care professional has no knowledge of, or is unable to access an existing ACP, there is a risk that a person’s preferences will not be met. It may also increase family/whānau stress where family/whānau are required to repeatedly inform health care professionals about the person’s expressed wishes.

ACP Documentation – Secondary Care

Work has been scheduled by the Central Region Information Systems Plan (CRISP) Stream 2 for a hospital-based module with possible linkages through to general practice patient management systems. This will enable primary and secondary care to access and view ACP documents.

A shared care platform would be invaluable for the transfer of ACP information across sectors and DHB regions. To date there is no regional solution in place to share ACP activity electronically, therefore policies and guidelines need to highlight the importance of ensuring ACP conversations undertaken or advance care plans completed, are recorded in the clinical record and where possible are noted in discharge letters and referral correspondence.

The future electronic solution for ACP needs management by the Central Region Health Informatics Strategic Advisory Group (CRHISAG) in collaboration with the Central Region Information Systems Plan (CRISP) team to ensure a robust regional solution.

ACP Documentation – Primary Care

A number of PHOs have implemented ACP READ codes in the general practice IT systems to enable identification of a person’s ACP. With the need to share the ACP activity between primary and secondary care it is essential that general practice teams READ-code the activity. Shared care records are currently only able to flag the fact that ACP discussions have started in primary care and/or completed plans are in place if the activity is READ-coded. These are:

- ACP discussions – Use local ACP discussions code (used when a member of the general practice team instigates an ACP conversation and provides an ACP patient information pack).
- ACP completed – Use local ACP completed code (used when a person has completed an ACP form).
- Advance Directive (AD) completed - administration code 9X.00.

“I have not been aware of any documentation in hospital discharge notes about ACP being discussed nor have any forms been brought to us or discussed with us.”

General Practitioner

“..we have an annual form that for those on Care Plus programme has a prompt regarding ACP. Without this regular prompt I am sure we would duck the need to initiate the ACP topic”.

Registered Nurse
ACP Documentation – Consumer

Empowering people to have conversations is a key enabler for successful ACP. Until technology catches up, hand-held ACPs are the best way to share ACP information.

Consumers should be advised to keep ACP documents in a place where health care professionals (including ambulance staff) can find them in an emergency situation. Likewise health care professionals need to encourage consumers to share copies of their ACPs with family/whānau and those whom they have nominated as an EPOA.

In some DHBs the Health Passport is well recognised as a communication tool as it contains information people want to share with health care professionals. Where DHB populations are familiar with and hold Health Passports, it should be encouraged that the decision-making section of the health passport is reviewed regularly and updated accordingly.

Relevant References

- Compass Health Publications – Community resources on advance care planning: http://www.compasshealth.org.nz/Publications

The Enabling Context for Social Change – The Application to ACP

- HWNZ funding support for training and development of resources.
- National ACP resources for community.
- Governance groups at local/sub-regional level.
- ACP Leads resourced to drive change.
- IT infrastructure coming to support storage and management.
- Guidelines or policies are developed to support implementation.
SECTION 4: ‘Can Do’

Health care professionals and organisations need to be prepared to have ACP conversations. They need to be capable of asking and understanding what matters most to people, and respecting their end-of-life wishes.

The National ACP Co-operative has developed a New Zealand strategy to training, which is supported by HWNZ. There are different levels of training which are designed to build a health care professional’s sense of self efficacy with ACP.

It is anticipated that building capacity in the workforce will take several years. ACP training requires significant investment of time and financial resource. As at 11 November 2013 there were 102 people trained to ACP Level 2 across the Central Region. Of those trained 60% are from primary care settings and 40% are from secondary care settings. Implementation of the regional training strategy which is supported and implemented locally will ensure that this investment is directed and delivers best value for money.

**Principles of the Training Approach**

- That implementation of the regional ACP training framework will be supported by Executive Leadership Teams.
- Collaboration with the Regional Training Hub to drive a strategic approach to training.
- Work in partnership with PHOs and aged residential care/ disability providers at a local level to maximise engagement in primary care.
- Ensure sustainability of ACP through the phased implementation of the training framework.
- Ensure that knowledge and skills in ACP are widely available to the health care workforce across the region.

**ACP Training Framework for the Central Region**

There are no international benchmarks identifying saturation levels of ACP training in the workforce. Likewise no quantitative information exists about where ACP conversations occur and by whom. Therefore the training framework in figure 5 utilises indicative workforce targets identified by the National ACP Co-operative.

“**The conversations that I now have are picking up on the cues that are given by clients that I would have missed before.**”

Registered Nurse
Figure 5: ACP Competency and Training Model\textsuperscript{22}

These targets are aspirational. ACP training needs to be phased across a number of years and balanced against a tight fiscal environment. The framework provides guidance to funders and health care professionals to inform strategic workforce planning. However implementation will need to be prioritised at a local level.

Training projections are designed to inform a regional strategy for ACP training but locally and sub-regionally governance groups will need to prioritise according to local need.

**Level 1 ACP Training Programme**

Level 1 is module based E-learning which is available free from the National ACP Co-operative website. It is designed for health care workers interacting with people and their families/whānau, who need to improve their understanding of ACP.

As it is module based, and free of charge, it is accessible to large numbers of the workforce. It requires approximately 2.5 hours self-directed training to complete the four modules.

A phased approach (time and targeted) will be required to reach 45% saturation level. Incorporating Level 1 into mandatory/basic training for some occupation groups would facilitate this. Level 1

\textsuperscript{22} Adapted from the National ACP Cooperative
training should be the regional priority in the short term, as it builds capacity and capability in the health workforce to engage in ACP conversations.

During the initial phase, health care workers should be targeted in clinical areas such as:

- General Practice teams.
- Clinical Nurse Specialist/Nurse Practitioners with relevant scope.
- Community-based /NGO health care professionals including Māori and Pacific Island providers.
- Aged residential care and home and community health care professionals.
- Acute Medical and Surgical Wards.
- Assessment Treatment and Rehabilitation Services/Health of Older People Services.
- Social Work Departments.
- Hospital Chaplains.
- InterRAI assessors.
- Emergency Department/Acute Assessment Unit.
- Intensive Care Unit.
- Outpatient health services that provide specialist support for long term conditions such as, cardiac, renal and respiratory.

Level 1 Training Projections – Primary Care and Community

Regional Level 1 training projections are based on staff likely to have an ACP conversation and applying the 45% target from the National ACP Co-operative. The nursing data is based on nursing registrations collected through the annual practicing certificate process and reported to the Health Practitioner Index (HPI).

Based on the above table 2 identifies projected Level 1 training numbers in primary care and community settings.

```
<table>
<thead>
<tr>
<th>DHB Area</th>
<th>Primary GPs</th>
<th>Maori Health Service Provider</th>
<th>Pacific Health Service Provider</th>
<th>PHO</th>
<th>Primary Health / Community Service</th>
<th>Rural</th>
<th>Rest Home / Residential Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>142</td>
<td>12</td>
<td>4</td>
<td>29</td>
<td>300</td>
<td>0</td>
<td>241</td>
<td>728</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>61</td>
<td>31</td>
<td>14</td>
<td>0</td>
<td>187</td>
<td>4</td>
<td>186</td>
<td>483</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>46</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>104</td>
<td>1</td>
<td>119</td>
<td>288</td>
</tr>
<tr>
<td>MidCentral</td>
<td>45</td>
<td>15</td>
<td>0</td>
<td>19</td>
<td>175</td>
<td>4</td>
<td>214</td>
<td>472</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>14</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>49</td>
<td>0</td>
<td>72</td>
<td>140</td>
</tr>
<tr>
<td>Whanganui</td>
<td>24</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>62</td>
<td>2</td>
<td>53</td>
<td>151</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>332</strong></td>
<td><strong>68</strong></td>
<td><strong>21</strong></td>
<td><strong>68</strong></td>
<td><strong>877</strong></td>
<td><strong>11</strong></td>
<td><strong>885</strong></td>
<td><strong>2262</strong></td>
</tr>
</tbody>
</table>
```

Table 2: Projected Level 1 training numbers in primary care and community settings

“It makes sense to me that they should be done in the person’s home community with help from people who know them well, when they are well and not stressed by hospital admission and, presumably, illness.”

General Practitioner
Training Projections – DHB Level 1

Table 3 identifies projected Level 1 training numbers for staff employed within DHBs. Based on estimates outlined 5,000 should have accessed Level 1 ACP training out of a total workforce of 11,085 for the Central Region (42.3%). This estimate is close to the National ACP Co-operative’s target of 45% for Level I training.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Allied &amp; Scientific</th>
<th>Care &amp; Support</th>
<th>Junior Medical</th>
<th>Nursing</th>
<th>Senior Medical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>99</td>
<td>241</td>
<td>324</td>
<td>1271</td>
<td>95</td>
<td>2030</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>36</td>
<td>98</td>
<td>162</td>
<td>498</td>
<td>32</td>
<td>826</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>44</td>
<td>69</td>
<td>122</td>
<td>427</td>
<td>28</td>
<td>691</td>
</tr>
<tr>
<td>MidCentral</td>
<td>36</td>
<td>88</td>
<td>128</td>
<td>637</td>
<td>43</td>
<td>932</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>6</td>
<td>15</td>
<td>10</td>
<td>144</td>
<td>8</td>
<td>182</td>
</tr>
<tr>
<td>Whanganui</td>
<td>13</td>
<td>44</td>
<td>28</td>
<td>239</td>
<td>15</td>
<td>339</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>235</strong></td>
<td><strong>555</strong></td>
<td><strong>775</strong></td>
<td><strong>3215</strong></td>
<td><strong>221</strong></td>
<td><strong>5000</strong></td>
</tr>
</tbody>
</table>

Table 3: Projected Level 1 training numbers for staff employed in DHBs

Training Gap – Level 1

At present there is no Learning Management System (LMS) connected to the Level 1 training modules. However the National ACP Co-operative has loaded a registration page against the second of the online level 1 modules. The second module is called ‘Talking about advance care planning with your patients’ and is directed at health care professionals. The registration page allows the National ACP Co-operative to collect demographic data (name, DHB region and email address). This data will act as a proxy of the uptake of ACP in the Central Region.

The National ACP Co-operative will be able to supply quarterly reports to the Central Region of those who have registered to complete this module.

Level 2 Training Programme

Level 2 requires four to six hours of pre-reading including completion of the Level 1 modules prior to attending a 2 ½ day course. It is aimed at health care professionals who want to improve their communication skills and ACP documentation.

Health care professionals in these areas may be

- clinical or client-facing roles where they have the opportunity to have ACP conversations with people and their families/whānau and/or
- educators who have a role in raising awareness across health care professionals or larger community groups.

To ensure sustainability there needs to be a geographical spread of Level 2 trained health care professionals to ensure local relationships can be developed and supported. Level 2 training should target health care professionals in clinical areas such as

- Health of Older People services

Co-ordinated by:
Outpatient health services that provide specialist support for long term conditions such as, cardiac, renal and respiratory.

- Oncology services.
- General practice teams.
- Aged Residential Care Facilities.
- Hospice and palliative care services.
- Community health services.
- Māori and Pacific health providers.

While the focus of Level 2 training should be on increasing the knowledge and expertise of health care professionals, locally there might be an identified need to train non-health care professionals to Level 2, such as hospital chaplains.

The “Advance Care Planning (ACP) Communication Training” has been endorsed by The Royal New Zealand College of General Practitioners (RNZCGP) and has been approved for up to 17.2 credits CME for General Practice Educational Programme Stage 2 (GPEP2) and Maintenance of Professional Standards (MOPS) purposes.

**Level 2 Training Projections – Primary Care and Community**

The ACP training cohort for Level two has been determined by identifying the staff who will ‘likely’ or with ‘some certainty’ have an ACP conversation based on role and clinical setting. Nursing data is based on nursing registrations collected through the annual practice certificate process and reported to Health Practitioner Index.

Level 2 training projections have been developed by applying the 5% target to staff identified where there is ‘some certainty’ that an ACP conversation could occur.

Table 4 identifies projected Level 2 training numbers in primary care and community settings.

<table>
<thead>
<tr>
<th>DHB Area</th>
<th>Primary GPs</th>
<th>Maori Health Service Provider</th>
<th>Pacific Health Service Provider</th>
<th>PHO</th>
<th>Primary Health / Community Service</th>
<th>Rest Home / Residential Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>16</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>30</td>
<td>24</td>
<td>74</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>18</td>
<td>19</td>
<td>48</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>12</td>
<td>29</td>
</tr>
<tr>
<td>MidCentral</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>16</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Whanganui</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>38</strong></td>
<td><strong>5</strong></td>
<td><strong>1</strong></td>
<td><strong>8</strong></td>
<td><strong>85</strong></td>
<td><strong>88</strong></td>
<td><strong>225</strong></td>
</tr>
</tbody>
</table>

Table 4: Projected Level 2 training numbers in primary care and community settings

“For example a man with motor neurone (MND) disease may decide that he doesn’t want to be tube fed or to be admitted to hospital to have a serious chest infection treated with IV antibiotics. To be able to do this he needs to have had a frank discussion with someone who can map out the likely scenarios for someone with MND.”

General Practitioner
The HPI dataset has informed the analysis in table 3. The primary limitation of the HPI dataset for these projections is that it relies on health care professionals identifying accurately where they work. Where there are small numbers of health care professionals, such as for Māori and Pacific Health, numbers will present as zero in the analysis. Governance groups will need to consider local workforce needs and prioritise training accordingly.

**Training Projections – DHB Level 2**

Table 5 identifies projected Level 2 training numbers for staff employed within DHBs. Based on estimates outlined below, 156 additional staff should have training at Level 2.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Allied &amp; Scientific</th>
<th>Care &amp; Support</th>
<th>Nursing</th>
<th>Senior Medical</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>5</td>
<td>9</td>
<td>47</td>
<td>0</td>
<td>61</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>2</td>
<td>3</td>
<td>20</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>3</td>
<td>3</td>
<td>15</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>MidCentral</td>
<td>2</td>
<td>4</td>
<td>26</td>
<td>1</td>
<td>33</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Whanganui</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>13</strong></td>
<td><strong>22</strong></td>
<td><strong>120</strong></td>
<td><strong>1</strong></td>
<td><strong>156</strong></td>
</tr>
</tbody>
</table>

Table 5: DHB Level 2 training projections

**Training Gap – Level 2**

Table 6 identifies the ACP workforce trained to Level 2 as at November 2013 by setting and occupational group. This is provided in more detail in Appendix 4.

<table>
<thead>
<tr>
<th>DHB Area</th>
<th>Primary GPs</th>
<th>Primary Nursing , Allied &amp; Care Support</th>
<th>Rest Home / Residential Care / Hospice</th>
<th>Secondary Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Care &amp; Support</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Nursing</td>
<td>25</td>
<td>10</td>
<td>15</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Other / Managerial</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Senior Medical</td>
<td>7</td>
<td>0</td>
<td>5</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total Trained by Setting</strong></td>
<td><strong>7</strong></td>
<td><strong>35</strong></td>
<td><strong>19</strong></td>
<td><strong>41</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

Table 6: Level 2 trained ACP health care professionals as at 11 November 2013
Table 7 identifies that a further 279 health care professionals should be trained to Level 2 region-wide to achieve the regional target of 381.

<table>
<thead>
<tr>
<th>DHB Area</th>
<th>Primary GPs</th>
<th>Primary Nursing, Allied Health &amp; Care Support</th>
<th>Rest Home / Residential Care / Hospice</th>
<th>Secondary Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>16</td>
<td>34</td>
<td>24</td>
<td>61</td>
<td>135</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>7</td>
<td>22</td>
<td>19</td>
<td>25</td>
<td>73</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>5</td>
<td>12</td>
<td>12</td>
<td>21</td>
<td>50</td>
</tr>
<tr>
<td>MidCentral</td>
<td>5</td>
<td>19</td>
<td>21</td>
<td>33</td>
<td>78</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Whanganui</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total Training Cohort</strong></td>
<td><strong>38</strong></td>
<td><strong>99</strong></td>
<td><strong>88</strong></td>
<td><strong>156</strong></td>
<td><strong>381</strong></td>
</tr>
<tr>
<td><strong>Numbers Trained</strong></td>
<td><strong>12</strong></td>
<td><strong>35</strong></td>
<td><strong>14</strong></td>
<td><strong>41</strong></td>
<td><strong>102</strong></td>
</tr>
<tr>
<td><strong>Training Gap</strong></td>
<td><strong>(26)</strong></td>
<td><strong>(64)</strong></td>
<td><strong>(74)</strong></td>
<td><strong>(115)</strong></td>
<td><strong>(279)</strong></td>
</tr>
</tbody>
</table>

Table 7: Regional training gap for ACP Level 2 by DHB region and occupational work group

Challenges exist for the Central Region when considering how to address the current training gap. A phased approach is required and DHB training plans will help to overcome some of these challenges. Key issues identified by stakeholders when considering the current ACP training gap is the need to balance and prioritise ACP training within financial constraints and the cost and challenges associated with releasing health care professionals for training.

A possible future constraint for training the workforce could be the number of Level 2 training courses offered by the National ACP Co-operative.

**Selection Criteria for Employer- Funded Level 2 ACP Training**

There needs to be careful selection of Level 2 trainees regionally and this needs to be balanced with local service needs. There is value in the ACP governance groups providing oversight of Level 2 applications.

Acknowledging that health care professionals have multiple roles and clinical responsibilities, priority should be given to

- permanent employees,
- those who hold a clinical position or health educator role and
- those who work 20 hours or more per week.

Applicants should be deferred where they are on short term contracts or are new graduates in their first two years of practice.

**Level 3 ACP Training Programme**

Level 3 Facilitators are selected by the National ACP Co-operative based on their skills and experience. They are obligated to meet the national training requirements and are contracted to the
Northern Regional Alliance (NRA) to deliver training. They are not permitted to train others in ACP outside of their contracted work for the NRA. Level 3 Facilitators must train a minimum of five courses per year for two years following their accreditation.

There are two doctors and one Clinical Nurse Specialist trained to Level 3 within the Central Region. Refer to Appendix 4 for more details. There may be a request for an additional facilitator from the Central Region. Careful consideration needs to be given to identifying the role of that person as it requires a significant time commitment over future years. For level 2 training to be sustainable, there needs to be sufficient Level 3 facilitators to deliver the courses.

**Projected Costs of ACP Training**

The full cost for Level 2 ACP training is $1,350 per participant. In 2013/2014 this has been subsidised by HWNZ. Projected training costs in table 8 have been modelled on the full participant cost as it is unknown whether courses in 2014/2015 will receive a HWNZ subsidy.

<table>
<thead>
<tr>
<th>Regional Summary</th>
<th>Expected Training Numbers</th>
<th>Expected Cost</th>
<th>Expected Training Hours Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Level 1</td>
<td>Level 2</td>
<td>Level 1</td>
</tr>
<tr>
<td>DHB Employed Staff</td>
<td>5,000</td>
<td>156</td>
<td>nil</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2,262</td>
<td>225</td>
<td>nil</td>
</tr>
<tr>
<td>Regional Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 8: Projected training costs for ACP

Level 1 is a free online training module with no direct cost to employers. However it represents 18,155 hours of professional development time. The projected costs make no allowance for travel and accommodation or hosting costs such as catering.

The cost allocation by DHB area is identified in table 9.

<table>
<thead>
<tr>
<th>DHB area</th>
<th>Primary</th>
<th>Secondary</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>$99,900</td>
<td>$82,350</td>
<td>$182,250</td>
</tr>
<tr>
<td>Hawkes Bay</td>
<td>$64,800</td>
<td>$33,750</td>
<td>$98,550</td>
</tr>
<tr>
<td>Hutt</td>
<td>$39,150</td>
<td>$28,350</td>
<td>$67,500</td>
</tr>
<tr>
<td>MidCentral</td>
<td>$60,750</td>
<td>$44,550</td>
<td>$105,300</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>$18,900</td>
<td>$8,100</td>
<td>$27,000</td>
</tr>
<tr>
<td>Whanganui</td>
<td>$20,250</td>
<td>$13,500</td>
<td>$33,750</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td>$303,750</td>
<td>$210,600</td>
<td>$514,350</td>
</tr>
</tbody>
</table>

Table 9: Cost allocation by DHB
The methodology for the training and funding assumptions are outlined in Appendix 5.

**Relevant Reading**


**The ‘Can Do’ Context for Social Change – The Application to ACP**

- National ACP Co-operative training programme for health care professionals.
- Easy and free access to resources online for health care professionals and people interested in ACP.
- All health care professionals are invited to be members of the Co-operative – hearing/seeing others have successful ACP conversations.
- Participation in local or sub-regional governance groups and peer support groups.
- Published guidance such as from NZ Medical Association and Medical Journal articles.
SECTION 5: Creating the Buzz

Raising awareness of any issue is not an easy undertaking and achieving lasting behavioural change is challenging. To raise public awareness of a topic is an attempt to inform the behaviours, attitudes and beliefs of a community.

ACP raising awareness needs to be inclusive of the wider public whilst ensuring that health care professionals are aware of ACP concepts and the processes. Social change needs to occur across a diverse audience where the central message is the same, but which requires different approaches.

Raising awareness with Māori, Pacific and Asian communities requires that ACP is framed within a relevant cultural context. The Co-operative is leading work on these developments and the Central Region DHBs are contributing expertise.

The implementation approach of ACP will vary by DHB region. Some may focus on raising awareness across the organisation and community, others the focus may be on education. Regardless of the approach, at a local level consideration needs to be given to system infrastructure, such as ACP documentation management in a person’s home, as well as in the health setting.

The demographic profile of a DHB region may also dictate the approach to raising awareness, which needs to be balanced with local health workforce capability and capacity.

Principles of Raising Awareness

- Establish buy-in from Executive Leadership Teams.

- The Central Region builds on national and local resources ensuring consistency of communication and messaging such as developing regional presentation packages for raising awareness.

- At a local level support national ACP initiatives such as the “Conversations That Count Day”

---

23 ‘Conversations That Count’ postcards from the National ACP Cooperative 2014
• Local or sub-regional clinical and community champions are identified to raise the awareness of ACP.

• Establish strategic engagement across the health and disability sector such as PHOs, public health agencies, Non-government Organisations (NGOs), aged care facilities, disability providers and ACC.

• Integrate ACP into clinical pathways.

**Raising Awareness with the General Public**

Targeted general public awareness should

• expose the local community to ACP through various channels, for example local radio, local papers, Citizen Advice Bureaux,

• provide education sessions to community organisations or businesses such as Lions, Rotary, Public Trust and Legal practices,

• make available ACP information, leaflets and posters to NGOs such as Alzheimer’s Society, Parkinson’s NZ and Cancer Society,

• make available ACP information leaflets and posters at general practices, disability providers, PHOs, public health agencies, aged residential care, and public waiting rooms,

• make promotional material available on noticeboards such as Grey Power, Citizens Advice Bureaux, and electronic noticeboards at, for example, the Returned Services’ Association or a Citizens’ Club,

• publish articles in Grey Power and Age Concern magazines,

• add promotional material to the DHB health of older people web pages where it does not already exist. Note that these pages are hyperlinked from the DHB Locator page on Alzheimer’s NZ website, so also provide a central message to a targeted population, and

• promote the “Conversations That Count” Programme with interested organisations to support community groups talking about planning for death and dying in a positive and productive way.

“Conversations that Count” (CTC) is a programme developed to enable non-health care professionals to discuss end-of-life issues. It is a ‘train the trainer’ model whereby key stakeholders in community organisations are trained so they can train other community groups.

Training is facilitated by Auckland DHB and supported by a written toolkit of ‘pick and mix’ modules for delivering in a community group setting. Auckland DHB had planned on delivering CTC in 2014, however due to recruitment issues this has been deferred.
**Raising Awareness within the Health Sector**

- Identify clinical champion(s) across the DHB.
- Inform Consumer Councils and Clinical Councils.
- Place promotional ACP material on noticeboards within targeted specialities.
- ACP presentations are undertaken at relevant professional forums.
- Engage with training hub network within each DHB and those with relevant training roles.

Raising awareness campaigns should be targeted in clinical settings where there is a high concentration of people

- with life-limiting conditions,
- with complex health needs,
- who are eligible for Care Plus and/or similar programmes,
- with disabilities who are ageing, including those with intellectual disability, and
- who frequently visit general practices and/or hospital.

**Relevant Reading**


**Creating the ‘Buzz’ for Social Change – The Application to ACP**

- National ACP Co-operative raising awareness campaigns such as “Conversations that Count”.
- Raising awareness at a local and sub-regional level across the health sector and in the community.
- Community and Clinical Champions spread the word through informal conversations and structured networks.
- ACP interest groups invite members from the community and health sector.
SECTION 6: Invitation

‘Talking about death and dying is hard. Most of us will not die suddenly. We all potentially have lots of time to think, talk and plan for our future and end-of-life care. Yet for most families this conversation does not happen or, if it does, then only when someone is very unwell. Many people don’t spend their last weeks and months doing what they value in a place they call home. They are undergoing treatments they would not have chosen given the choice, away from their homes in a hospital or high care facility, isolated from their families by visiting hours or distance. Many don’t get to say what they want to the important people in their lives, don’t get to say I love you, thank you, sorry and goodbye.

Advance Care Planning helps us think about and share what is important, it helps us think about and plan what treatments we do and don’t want, it helps us clarify how we want to be cared for as we approach the end of our lives.’

The invitation to talk about ACP needs to be compelling and come from a credible source. Engaging in ACP conversations is voluntary and some people may not be ready for an ACP conversation. However willingness to engage in the conversation may change over time and health care professionals need to be prepared to offer discussions at a later stage.

Some people will initiate the ACP conversation with health care professionals. There are many reasons why a person may wish to make decisions about their future care. These include definite views about treatments they do or do not want, experiences of others around them, not wanting to be a burden on others and concern for self.

Regardless of who initiates the conversation, the invitation must include provision of good quality ACP resources and references so people know how to get started.

The ethical challenges of ACP conversations

The National Ethics Advisory Committee (NEAC) is supportive of people being offered the opportunity to engage with health care professionals in ACP conversations, however they note engagement in discussions is a voluntary decision.

‘Advance care planning is not a panacea. ACP carries potential risks and tensions even when it is done well and these can be particularly exacerbated by an inadequate process. For instance, ACP must find a balance between documenting specific instructions that in unforeseen circumstances may not be what the patient would have wanted and non-specific expressions of wishes that must then be interpreted not by the patient but by family members and health professionals.’

“Most people are very positive when the subject is raised...many people make comments such as “I have meaning to do this and thank you for giving me the prod”.”

Practice Nurse

---

24 Dr Barry Snow: Conversations that Count Day 16 April 2014 Information Pack
The NEAC consulted on ‘Ethical Challenges in Advance Care Planning’ late 2013. The aim of the document was to explore the ethical challenges that health care professionals face in ACP and to provide practical assistance to help ensure good outcomes for consumers and health care professionals from the advance care planning process. This document will be published mid 2014.

**Principles**

- Central Region supports national invitations to act, such as the ‘Conversations That Count’ day.
- Clinical and community champions are promoted locally and sub-regionally, inviting health care professionals and communities to act.
- ACP conversations become integrated into normal interactions, whether that is part of health care consultation or the invitation from a church leader.
- Health care professionals need to be confident in their communication skills and have knowledge of the legal framework of advance directives and advance care.
- ACP conversations need to occur at the right time, in the right place and with the right person.
- Vignettes of successful engagement with ACP are promoted, from the perspective of the consumer and the health care professional.
- Good quality printed resources are available for health care professionals to share with consumers.

**Consumer Resources**

To enable health care professionals to initiate ACP conversations with consumers good quality ACP resources need to be available. Whilst the population are increasingly able to access internet-based resources, during face to face discussion a paper-based resource is often preferred to assist engagement.

The National ACP Co-operative resources are all available online, although some of these are quite long (28 pages).

An opportunity exists for the Central Region to brand resources with the six DHB logos. This will assist with communicating to consumers that ACPs are a regional initiative and should they be transferred between DHBs their ACP has currency with all health care professionals.

**Relevant Reading**

- National Ethics Advisory Committee (2014) *Ethical Challenges in Advance Care Planning*; (Due to be published May/June 2014)
The Invitation for Social Change – The Application to ACP

- Nationally-lead promotion, such as the 'Conversations the Count' Campaign.
- Community and consumer champions of ACP invite people to talk about ACP for themselves and for others.
- Health care professionals invite other health care professionals to think about ACP for themselves and their patients.
SECTION 7: Sustained Adoption

There is mixed evidence of the benefits of ACP. Recent studies suggest it facilitates the delivery of care more in keeping with a person’s wishes and increases their and family/whānau satisfaction with care at the end-of-life.

‘While we do not know whether an inadequate ACP process is better than no planning process at all, a good process is clearly a desirable goal. Further research about the impact of advance care planning on patient outcomes will be important to inform this debate.’

The Triple Aim is a pivotal quality improvement framework providing direction at a regional level to deliver sustainable patient-focused high quality care.

Figure 6: New Zealand Triple Aim

There is no baseline for measurement of sustained adoption of ACP in the Central Region, therefore a regional priority will be to agree and commit to a set of outcomes which can be collected and reported on.

Principles

- Measurement of ACP is framed within the NZ Triple Aim methodology.
- At a minimum the Central Region collect and report on the same outcome measures used by the Northern Regional Alliance as outlined in this section.
- DHBs collaborate locally and regionally to develop agreed primary care, age residential care and a DHB ACP measures.
- Commit to standardisation of policies, guidelines, systems and processes where it makes sense to do so.

Health Sector Adoption of ACP

Understanding the adoption of ACP by the health sector requires a multi-faceted approach and at a minimum should be consistent with the outcomes the Northern Regional Alliance collect. Those collected by the Northern Regional Alliance are identified in italics. Quantitative measures that could be collected are:

- **Number of health care professionals trained to Level 2.**
- **Number of patient-related ACP conversations – reported quarterly by Level 2 health care professionals**27. To inform this indicator Level 2 trainees are encouraged to maintain a reflective log which records the date, patient’s NHI, and note if an ACP was
  - initiated
  - discussed
  - documented
- **Number of people who have completed module 2 of the Level 1 training modules by DHB region.**
- **Number of ACP READ codes activated in general practice patient management systems.**
- **Patient level audit in aged residential care of how many people have an ACP on record.**
- **Training sessions delivered to health care professional groups who work with vulnerable populations such as Long Term Condition Nurses, Clinical Community Nurses and Māori Health Nurses.**
- **The number of ACP conversations recorded in the InterRAI clinical data. This would need to be a snapshot in time and could provide detail from the Notes Pages section on those**
  - who have been given ACP information and/or
  - where the InterRAI assessment has alerted the General Practice team of an ACP in existence.
- **Overall coding query on how many people have ‘living wills’ recorded in their InterRAI.**

Appendix 3 provides a snapshot of ACP knowledge and skills utilisation in the Central Region in 2013. Qualitative measures that reflect the experience of the person and their family /whānau do need to be developed. These are best considered at a local or sub regional level.

Future development could be that ACP becomes a regional health indicator once CRISP is fully implemented in the Central Region. The rationale for this is that

- **ACP exists at person level,**

27 Information is reported to the National ACP Cooperative
• it helps quantify how informed the general population is on ACP,
• it quantifies how effective health care professionals have become at documenting the conversations they have engaged in with people on ACP,
• results could inform policy or guidance at a local and regional level, and
• as a health indicator, it would support regional planning.

Community Adoption of ACP

For social change to occur the community needs to be at the forefront of driving change. The Northern Regional Alliance collects those measures in italics and should be the minimum collected within the Central Region. To measure community adoption of ACP the following indicators are possible.

• Number of consumer engagement hours delivered by Level 2 trained health care professionals to consumer groups or fora.
• The number of patient-related ACP leaflets or ACP plans that have been distributed.
• Number of community representatives on the local and sub-regional governance groups.

Health sector measures will also indicate the acceptance of ACP to the community, as an increasing number of ACP conversations recorded in patient management systems will indicate a decision to act on ACP and record advance care preferences.

Relevant Reading

## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directive (AD)</td>
<td>‘Instructions that consent to, or refuse, specified medical treatment or procedure in the future. Advance directives are defined in the Code of Health and Disability Services Consumers’ Rights (the Code) as written or oral directives in which the patient makes a choice about a possible future health care procedure, and this choice is intended to be effective only when the patient is no longer competent. For this reason, advance directives are also, though less frequently, referred to as ‘living wills’. Right 7(5) of the Code gives every consumer the legal right to use an advance directive in accordance with common law.’</td>
</tr>
<tr>
<td>Advance Care Plan (ACP)</td>
<td>‘An advance care plan is the desired outcome of the ACP process. Ideally, it is documented rather than verbal. While this might be done on a form designed specifically for that purpose, it can be in any format. It should be accessible to current and future health care providers and to family/whānau members according to the person’s wishes. An advance care plan is an articulation of wishes, preferences, values and goals relevant to all current and future care. It is not intended to be used only to direct future medical treatments and procedures when the person loses capacity to make their own decisions (becomes incompetent). An advance care plan can and should, however, be used to inform decision-making in this situation along with other measures such as discussions with the individual with an EPA (where one has been appointed) and with family/whānau.’</td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>‘Advance care planning (ACP) is a process of discussion and shared planning for future health care. ACP is focused on the individual and involves both the person and the health care professionals responsible for their care. ACP may also involve the person’s family/whānau and/or carers if that is the person’s wish. The planning process assists the individual to identify their personal beliefs and values and incorporate them into plans for their future health care. ACP provides individuals with the opportunity to develop and express their preferences for care informed not only by their personal beliefs and values but also by an understanding of their current and anticipated future health status and the treatment and care options available. The ACP process may result in the person choosing to write an advance care plan (see below) and/or an advance directive and/or to appoint an enduring power of attorney (EPA). If a person is identified as having strong views or preferences about medical treatments and procedures, they should be advised to consider completing an advance directive.’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Champion</strong></td>
<td>Trained to Level 2. Role is to drive clinical discussions, influence management-level decisions and provide education to wider health care professionals or groups (within capacity).</td>
</tr>
<tr>
<td><strong>Community Champion</strong></td>
<td>Raising awareness within own networks, NGOs, etc. Not formally trained but recommended that they have completed the Level 1 online learning modules so that messaging is correct.</td>
</tr>
<tr>
<td><strong>Enduring Power of Attorney (EPOA)</strong></td>
<td>‘An authority given by a patient, while they are competent, to another person, in order for that person to act for the welfare of the patient only once the patient is mentally incompetent. Under new legislation (2007), a medical certificate that the patient is mentally incapable is required before a person with an EPA can act in respect of certain matters. Note there are two types of EPA (property and personal care and welfare).’</td>
</tr>
<tr>
<td><strong>Health care professional</strong></td>
<td>A practitioner such as a doctor, dentist, physiotherapist, midwife, social worker, optometrist or community pharmacist, licensed, certified or registered in New Zealand to provide health care.</td>
</tr>
<tr>
<td><strong>READ Codes</strong></td>
<td>READ Codes are a coded thesaurus of clinical terms and are the basic means by which health care professionals record patient findings and procedures in health IT systems across primary and secondary care.</td>
</tr>
<tr>
<td><strong>Sub-regional</strong></td>
<td>Two or more DHB regions working together.</td>
</tr>
<tr>
<td><strong>Whānau</strong></td>
<td>‘Kūia, koroua, pakeke, rangatahi, tamariki. In this document the term whānau is not limited to conventional definitions, but recognises the diversity of families within Māori communities. It is up to each individual to define for themselves who their whānau is.’</td>
</tr>
</tbody>
</table>

---

Appendix 1: Central Region ACP Contacts

To support regional collaboration and networking, table 10 identifies key contacts within the Central Region for ACP.

<table>
<thead>
<tr>
<th>DHB Region</th>
<th>ACP Contact Person</th>
<th>Email Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital &amp; Coast DHB</td>
<td>Vicky Noble</td>
<td><a href="mailto:Vicky.noble@sidu.org.nz">Vicky.noble@sidu.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Director of Nursing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Health Care and Integrated Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr Maureen Coombs</td>
<td><a href="mailto:Maureen.Coombs@ccdhb.org.nz">Maureen.Coombs@ccdhb.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Professor in Clinical Nursing (Critical Care) Graduate School of Nursing Midwifery and Health Victoria University and Capital and Coast District Health Board</td>
<td></td>
</tr>
<tr>
<td>Capital &amp; Coast Primary Care</td>
<td>Trevor Daniel</td>
<td><a href="mailto:Trevor.daniell@paradise.net.nz">Trevor.daniell@paradise.net.nz</a></td>
</tr>
<tr>
<td>Hutt Valley DHB</td>
<td>Dr Zainab Contractor</td>
<td><a href="mailto:Zainab.contractor@huttvalleydhb.org.nz">Zainab.contractor@huttvalleydhb.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Senior Medical Officer – Geriatrics and Rehabilitation Medicine</td>
<td></td>
</tr>
<tr>
<td>Hutt Valley Primary Care</td>
<td>Bridget Allan</td>
<td><a href="mailto:Bridget.A@teahn.org.nz">Bridget.A@teahn.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Chief Executive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Te Awakairangi Health Network</td>
<td></td>
</tr>
<tr>
<td>Wairarapa DHB</td>
<td>Anne Savage</td>
<td><a href="mailto:anne.savage@wairarapa.dhb.org.nz">anne.savage@wairarapa.dhb.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Nurse Educator Palliative Care</td>
<td></td>
</tr>
<tr>
<td>Wairarapa Primary Care</td>
<td>Anna Reed</td>
<td><a href="mailto:Anna.Reed@mastertonmedical.co.nz">Anna.Reed@mastertonmedical.co.nz</a></td>
</tr>
<tr>
<td></td>
<td>Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>Hawkes Bay DHB</td>
<td>Dr Lucy Fergus</td>
<td><a href="mailto:Lucy.fergus@hbdhb.govt.nz">Lucy.fergus@hbdhb.govt.nz</a></td>
</tr>
<tr>
<td></td>
<td>Geriatrician</td>
<td></td>
</tr>
<tr>
<td>Hawkes Bay Primary Care</td>
<td>Terrie Spedding</td>
<td><a href="mailto:Terrie@healthhb.co.nz">Terrie@healthhb.co.nz</a></td>
</tr>
<tr>
<td></td>
<td>Registered Nurse / Diabetes Nurse Specialist Health Hawke’s Bay – Te Oranga Hawke’s Bay</td>
<td></td>
</tr>
<tr>
<td>Midcentral DHB</td>
<td>Dr Kirsten Holst</td>
<td><a href="mailto:Kirsten.holst@midcentraldhb.govt.nz">Kirsten.holst@midcentraldhb.govt.nz</a></td>
</tr>
<tr>
<td></td>
<td>Physician and Geriatrician</td>
<td></td>
</tr>
<tr>
<td>Midcentral Primary Care</td>
<td>Liz Elliott</td>
<td><a href="mailto:Liz.elliott@midcentraldhb.govt.nz">Liz.elliott@midcentraldhb.govt.nz</a></td>
</tr>
<tr>
<td></td>
<td>Nurse Co-ordinator</td>
<td></td>
</tr>
<tr>
<td>DHB Region</td>
<td>ACP Contact Person</td>
<td>Email Address</td>
</tr>
<tr>
<td>------------------</td>
<td>----------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Whanganui DHB</td>
<td>Jennie Fowler</td>
<td><a href="mailto:Jennie.fowler@wdhb.org.nz">Jennie.fowler@wdhb.org.nz</a></td>
</tr>
<tr>
<td></td>
<td>Strategic Advisor for Health of Older</td>
<td></td>
</tr>
<tr>
<td></td>
<td>People</td>
<td></td>
</tr>
<tr>
<td>Whanganui</td>
<td>Dr Alan Mangan</td>
<td><a href="mailto:alanm@aramohohealthcentre.co.nz">alanm@aramohohealthcentre.co.nz</a></td>
</tr>
<tr>
<td>Primary Care</td>
<td>Aramoho Health Centre</td>
<td></td>
</tr>
</tbody>
</table>

Table 10: Key contacts for ACP within the Central Region
Appendix 2: Stocktake of ACP Implementation Across the Central Region

In April 2013 a stocktake was undertaken across the Central Region seeking the views of DHBs, PHOs and palliative services regarding their progress with implementing ACP. Following are the summary points from the stocktake:

- Implementation of ACP regionally is sporadic.
- Where there was evidence of strong clinical leadership or funded leadership local areas were able to raise the profile of ACP and develop implementation.
- In most DHBs there is no strategic mandate to implement ACP.
- Whanganui DHB and Capital & Coast DHB are the furthest along in embedding ACP conversations and processes into their communities and health care systems.
- Whanganui DHB and Capital & Coast DHB have strong collaboration with their PHOs.
- There is an inequity of access to training regionally primarily driven by budgets for training.
- Barriers to implementation are described as funding (printing of consumer resources, training), information technology (recording and sharing of ACP plans) and time (to engage patients in ACP conversations).
Appendix 3: Survey of ACP Trained Staff in the Central Region

During April-June 2013, people known to have been trained to Level 2 and 3 in ACP (73 people) to asked to participate in an online survey. There was a 50% response rate to the survey. The survey was anonymous and conducted via Survey Gizmo. Following is a summary of the results:

Utilisation of ACP Knowledge and Skills

- 60% of respondents reported they had ACP conversations at least 1-2 times per week.
- 42% of respondents stated they recorded ACP conversations at least 1-2 times per week.
- 67% of respondents provide group education sessions on ACP.
- 72% of group training is provided to health care professionals or health agencies, 21% with community agencies or the public, and 7% with patient groups.
- 90% of those providing education to groups do so less than twice a month.
- 26% of respondents mentioned that time was a barrier to utilising their ACP knowledge on a day-to-day basis.
- 68% of respondents use the national ACP forms with their clients/groups.
### Appendix 4: Regional View of ACP Training

Table 9 identifies Level 2 and Level 3 trained health care professionals in the Central Region by staff type and clinical setting. This information is correct as at November 2013.

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Training Level Achieved</th>
<th>Occupational Group</th>
<th>ACP Training by DHB Geographical Region</th>
<th>Total Trained by Occupational Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCDHB</td>
<td>Level 2</td>
<td>Allied</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CCDHB</td>
<td></td>
<td>Care &amp; Support</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CCDHB</td>
<td></td>
<td>Nursing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CCDHB</td>
<td></td>
<td>Other / Managerial</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>CCDHB</td>
<td></td>
<td>Senior Medical</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CCDHB Total</td>
<td></td>
<td></td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>HBDHB</td>
<td>Level 2</td>
<td>Allied</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>HBDHB</td>
<td></td>
<td>Nursing</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>HBDHB</td>
<td></td>
<td>Other / Managerial</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>HBDHB</td>
<td></td>
<td>Senior Medical</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>HBDHB Total</td>
<td></td>
<td></td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>HVDHB</td>
<td>Level 2</td>
<td>Nursing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HVDHB</td>
<td></td>
<td>Other / Managerial</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HVDHB</td>
<td></td>
<td>Senior Medical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HVDHB Total</td>
<td></td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>MCDHB</td>
<td>Level 2</td>
<td>Allied</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>MCDHB</td>
<td></td>
<td>Nursing</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>MCDHB</td>
<td></td>
<td>Other / Managerial</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MCDHB</td>
<td></td>
<td>Senior Medical</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>MCDHB Total</td>
<td></td>
<td></td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>WaDHB</td>
<td>Level 2</td>
<td>Nursing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>WaDHB</td>
<td></td>
<td>Senior Medical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>WaDHB Total</td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>WhDHB</td>
<td>Level 2</td>
<td>Allied</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>WhDHB</td>
<td></td>
<td>Nursing</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>WhDHB</td>
<td></td>
<td>Other / Managerial</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>WhDHB</td>
<td></td>
<td>Senior Medical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>WhDHB Total</td>
<td></td>
<td></td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td></td>
<td>5</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 11: Level 2 and Level 3 trained health care professionals at 11th November 2013
Appendix 5: Workforce Analysis Methodology

DHB ACP Cohort

As at 30 June 2013 the Central Region’s DHBs (excluding primary care) employed 11,085 full time equivalents (FTEs) as outlined in table 10. This information was sourced from DHB Shared Services (DHBSS) Health Workforce team, extracted August 2013.

<table>
<thead>
<tr>
<th>DHB Total Workforce</th>
<th>CCOHBS</th>
<th>HBDHB</th>
<th>HV/DHB</th>
<th>MCHOB</th>
<th>Wa/DHB</th>
<th>Wh/DHB</th>
<th>Regional Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allied and scientific</td>
<td>582</td>
<td>260</td>
<td>299</td>
<td>242</td>
<td>36</td>
<td>81</td>
<td>1501</td>
</tr>
<tr>
<td>Care and support</td>
<td>453</td>
<td>256</td>
<td>214</td>
<td>194</td>
<td>33</td>
<td>105</td>
<td>1255</td>
</tr>
<tr>
<td>Corporate and other</td>
<td>1023</td>
<td>434</td>
<td>365</td>
<td>540</td>
<td>96</td>
<td>164</td>
<td>2622</td>
</tr>
<tr>
<td>Junior medical</td>
<td>324</td>
<td>102</td>
<td>122</td>
<td>128</td>
<td>10</td>
<td>26</td>
<td>774</td>
</tr>
<tr>
<td>Midwifery</td>
<td>98</td>
<td>41</td>
<td>28</td>
<td>42</td>
<td>10</td>
<td>19</td>
<td>238</td>
</tr>
<tr>
<td>Nursing</td>
<td>1981</td>
<td>649</td>
<td>961</td>
<td>766</td>
<td>165</td>
<td>292</td>
<td>4014</td>
</tr>
<tr>
<td>Senior Medical</td>
<td>277</td>
<td>103</td>
<td>99</td>
<td>130</td>
<td>26</td>
<td>45</td>
<td>680</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4338</td>
<td>1906</td>
<td>1689</td>
<td>2040</td>
<td>376</td>
<td>735</td>
<td>11085</td>
</tr>
</tbody>
</table>

Table 12: Total DHB Workforce

While there is an expectation that the entire workforce will have a basic understanding of ACP, Levels 1 and 2 are for staff that generally have direct contact with patients and their families.

DHB Workforce for ACP Training Levels 1 and 2

The ACP training cohort for Level two within DHBs has been determined by identifying the staff most likely to have the opportunity or be in a position to have an ACP conversation based on role and clinical setting. This was determined by examining the roles and the likelihood of having ACP conversations.

FTE information sourced from DHBs in respect to nursing roles lacked detail regarding the clinical setting making it difficult to ascertain ACP conversation likelihood. More detailed understandings can be gained through the annual practice certificate process and reported to HPI but the numbers do not fully collate for this analysis, therefore DHB-reported information has been used.

Primary Workforce for ACP Training Levels 1 or 2

Information to identify the number of general practice doctors was sourced from the NZ Medical Council. Primary Care nursing requirements were determined by accessing annual practicing certificate data reported to the National HPI and based on roles within clinical setting.

Primary Health Sector Training Numbers Projections

Primary Care Doctors

Information to identify the number of general practice doctors was sourced from the NZ Medical Council. Assuming that 45% of GPs should have access to ACP Training, Table 11 provides a
breakdown of GP numbers for ACP training.

<table>
<thead>
<tr>
<th>DHB area</th>
<th>Number</th>
<th>Total GPHours</th>
<th>FTE</th>
<th>ACP Training 45%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital and Coast</td>
<td>316</td>
<td>10384.5</td>
<td>259.6</td>
<td>142.2</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>136</td>
<td>4783.9</td>
<td>119.6</td>
<td>61.2</td>
</tr>
<tr>
<td>Hutt</td>
<td>103</td>
<td>3619.7</td>
<td>90.5</td>
<td>46.35</td>
</tr>
<tr>
<td>MidCentral</td>
<td>99</td>
<td>3781.3</td>
<td>94.5</td>
<td>44.55</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>32</td>
<td>1251</td>
<td>31.3</td>
<td>14.4</td>
</tr>
<tr>
<td>Whanganui</td>
<td>53</td>
<td>2214.5</td>
<td>55.4</td>
<td>23.85</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>739</td>
<td>26034.9</td>
<td>650.9</td>
<td>332.55</td>
</tr>
</tbody>
</table>

Table 13: GP numbers in the Central Region for ACP training

**Nursing Roles outside of a DHB Setting (Primary Care and Other Settings)**

The following clinical settings make up the primary sector dimension for ACP Training:

- Maori Health Service Provider (Headcount 101)
- Pacific Health Service Provider (Headcount 23)
- PHO (Headcount 84)
- Primary Health Care (PHO)/Community Service (non DHB) (Headcount 1,076)
- Rest Home/Residential Care (Headcount 1,021)
- Rural (Headcount 15)

**Training Risks**

- Level 3 training to date has been undertaken by senior medical staff that may or may not have the time to maintain certification by training in other DHBs across the country.

- That ACP training cannot be accommodated within in current DHB orientation and training provisions.